DEPAI	RTMENT OF HEALTH	HAND HUMAN SERVICES & MEDICAID SERVICES	·	1015	FORM APPROV OMB NO. 0938-0
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NO	(%) DATE SURVEY COMPLETED
		445071	a. wing		40400040
	PROVIDER OR SUPPLIER ORNE COUNTY NURSH		1.	REET ADDRESS, CMY, STATE, ZIP CODE 1850 OLD KNOXVILLE ROAD FAZEWELL, TN 37879	10/10/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TÉMENT OF DEFICIÉNCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	NO BE CONFLET
F 000	: INITIAL COMMENT	s	F 000		
SS=D	investigation #29354 Claiborne County No. 2012. No deficiencies complaint investigation Part 483, Requirement Pacilities. 483.20(g) - (j) ASSE: ACCURACY/COORD The assessment must resident's status. A registered nurse most each assessment with participation of health A registered nurse most participation of health assessment is completed individual who consessment must sign hat portion of the assessment with participation of the assessment must sign hat portion of the assessment in a re- ubject to a civil mone-	ition survey and complaint were completed at uraing Home on October 10, as were cited related to on #29354 under 42 CFR ents for Long Term Care SSMENT DINATION/CERTIFIED at accurately reflect the professionals. Ist sign and certify that the eted. In and certify the accuracy of essment. Medicaid, an individual who certifies a material and	F 278	Resident # 8, identified in this deficient practice will have he Quarterly Minimum Data Set updated to reflect accurately humber of falls, by the MDS Coordinator at the next schedulpdate. Responsible Person: MDS Coordinator Completion Date: 11/27/2012 All other Residents utilizing to beds are being reviewed to ideany reported "roll outs" not in as falls on their Quarterly Min Data Sets. Any identified deficiencies will have accurate number of "roll outs" classific falls on their next scheduled	er aled 2. ///21/12 ow cutify cluded imum
pr pr	o certify a material and esident assessment is enalty of not more that seessment,	subject to a civil money		Responsible Person: MDS Coordinator	
TORY DI	RECTOR'S OR PROVIDER	TIPPI IPP REPRESENTATIVES CHOMAT	ile	TITLE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2587(02-99) Previous Versions Observio

Event (0:514411

Facility ID: TN1301

If continuation shoot Page 1 of 12

page 3 NEWS OF BEST CHESTON ひじょふアサントンア ペイ r 3/14 UEPAKTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAK OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445071 10/10/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1880 OUD KNOXVILLE ROAD CLAIBORNE COUNTY NURSING HOME TAZEWELL, TN 37879 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION PREFIX TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 278 | Continued From page 1 F 278 The MDS and PPS coordinators Clinical disagreement does not constitute a have been educated to include "roll material and false statement. out of low beds" as a fall, using the state definition of a fall being any This REQUIREMENT is not met as evidenced unplanned change of plane. by: Based on medical record review, review of facility They were also instructed to investigation, and interview, the facility failed to accurately report these on Quarterly accurately document the number of falls on the MDS profiles. Quarterly Minimum Data Set for one resident (#8) Responsible Person: Director of of eighteen residents reviewed. Nursing ! The findings included: Resident #8 was admitted to the facility on May All event reports will be reviewed 11, 2011, and readmitted to the facility on May by Director of Nurses or his 29, 2012, with diagnoses including Gastrostomy, designee and the MDS Coordinator Fallure to thrive, Congestive Heart Failure, to ensure that "roll outs of low Hypoxemia, Rheumatok Arthritis, Vasculer beds" are reported on MDS as falls. Dementia, and Psychosis. # of "low bed roll outs" reported per Review of facility investigations revealed the Resident + # of falls reported per resident had falls on June 12, 2012; June 15, Resident = the total # of falls 2012; July 4, 2012; July 18, 2012; July 20, 2012; documented on Quarterly MDS July 29, 2012; August 14, 2012 and August 31, updates. This data will be collected 2012, for a total of eight (8) falls between June and aggregated by the MDS 12, 2012 and August 31, 2012, Coordinator and reported to the Director of Nursing and Review of a Quarterly Minimum Data Set (MDS) dated September 4, 2012, revealed Administrator on a monthly basis. documentation the resident had one fall with Responsible Person: MDS injury since prior MDS Initial Assessment dated Coordinator

FORM CMS-2567(02-96) Previous Versions Obsolete

June 11, 2012.

Interview on October 9, 2012, at 3:00 p.m., in the

Dining Room, with the MDS Coordinator, confirmed the Quarterly MDS did not accurately document the number of falls the resident had

Event ID: 614411

Facility ID: TN1301

if continuation sheat Page 2 of 12

	DELAKTIMENT OF HEALT	H AND HIMAN SERVICES		••		
	CENTERS FOR MEDICARI	F & MEDICAID SERVICES			FOR	MAPPROVE
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT#ICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION	(X3) DATE	O. 0938-039 SURVEY
1		445071	8. WING		Ì	
ļ	NAME OF PROVIDER OR SUPPLIER	4450/1				/10/2012
ļ	CLAIBORNE COUNTY NURS!	NG HOME	} 6	itreet address, city, state, zp co 1850 OLD KNOXVILLE ROAD	ΧŒ	
ŀ				TAZEWELL, TN 37878		
	PREPIA: CAUM DERIGENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	i should be	COMPLETION COMPLETION CATE
	F070		- 			
	F 278: Continued From page	ge 2	F-27	8 1		→
	experienced since t	he prior MOS,	ļ	Pana		1
	F 322 483.25(g)(2) NG TR	EATMENT/SERVICES -	: F 32	zi R322	_ 4L:_	1.14/10
	SS=D RESTORE EATING	SKILLS	i	Resident # 5 identified in		11/16/12
	i Beant on the source		1	deficient practice immed		
	resident the feelille	Chensive assessment of a		the date and time added		1
	Who is fed by a nase	must ensure that a resident gastric or gastrostomy tube	•	enteral feeding container		1
	receives the annum	late treatment and services		LPN providing resident		1
	to prevent aspiration	pheumonia, dianthea,		Responsible Person: Di	rector of	i
	vomiting, dehydration	n metabolic abnormalities,	ļ	Nursing		Į
	Bedavisard-Isser Dasivinges	Ulcers and to restore if	,	41144		
	possible, normal eati	ng skilis.				ļ
	İ			The licensed staff memb	er identified	
	The Stot Potester	!		as involved in the deficie	ant practice	1
	i phi	ls not met as evidenced		was reeducated by the D	irector of	1
		the court find a market of the court of the		Nurses on the importance	e of	i i
	i falled to lotel and del	n and interview, the facility		compliance with facility]
	One resident (#5) of a	e tube feeding solution for lighteen residents reviewed.		and procedures regarding		j j
	;	Aureau resideur (646M90'		and dating of enteral fee		
	The fladings included:	·		100% of Residents receiv		
	1		1	enteral feedings have be		! [
	Resident #5 was adm	itted to the facility on July		reviewed to ensure feeding		
	1 15, 2009, and readmit	ted to the facility on June 6		container is correctly lab		[]
	'ZU12, With diagnoses	noteding Chronic Kidney	i	dated.	cice and	!
	LIBERSE, UNCONTROLLED	Diabetes, Dementis,		Responsible Person: Dir	ector of	
	Psychosis, Peripheral	Vescular Disease,	-	Nursing	2001 01	1
	Gastrostomy, and Stag	36 4 Pressure Olcer.	- !	Musing ∮o is a Fata	Ì	', , <u> </u>
	Observation of the resi	Ident on October 8, 2012,		7 () 4 (720)	· j	1 101 -
	at 1:00 p.m., 2:00 p.m	, 3:45 p.m., and 4:30 p.m.,	;	1009/ of the lines and must	sing staff	- [
	revealed the resident of	eceiving continuous tube]	100% of the licensed nur	~	-
	reeding solution at 68 r	이 (milliters) per hour via	. j	will be educated on the in		}
	pump and gastrostomy	tube (a tube surgically	į	of compliance with facili	,	
	placed into the stomec	h through the abdominal	- 1	and procedure with empl		
	Waii). Continued obser	vation revealed the	1	labeling and dating enter	~ .	
	solution was contained	in a 1200 ml opaque]	containers. Attendance of		1
	plastic container with th	e manufacturer's label	{	session will be verified b	y	,

COTETIOTEE 13.70 DEPT. OF REALTH AND HUMAN SERVICES

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F 2/14 FORM APPROVED

CENT	RS FOR MEDICARI	& MEDICAID SERVICES			FOR	RM APPROVE 10. 0938-038
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	A. BUILD		(X3) DATE	SURVEY PLETED
		445071	B. WING		1	/10/2012
NAME OF	PROVIDER OR SUPPLIER		Ís	TREET ADDRESS, CITY, STATE, ZIP CODE		110/2012
CLAIBO	RNE COUNTY NURSI	NG HOME	1	1850 OLD KNOXVILLE ROAD TAZEWELL, TN 37879		
(X4) ID PREFIX YAG	. KEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION)	PREFIX YAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REPERENCED TO THE APA DEFICIENCY)	OULD BE	COMPLETION DATE
F 323 SS=D In b fa dc ini re (#	Interview with LPN # p.m. at the 200 half in administration of the 7, 2012, at 10:00 p.m. had failed to ensure administration was o 483.25(h) FREE OF HAZARDS/SUPERVITHE facility must ensure environment remains as is possible; and easied particular supervision prevent accidents. This REQUIREMENT y: Based on medical receiview of facility investicity failed to ensure evices for two resider openty ensure the sauring transfer using a pocument and ensure the reventions to prevent environs to preventerventions to preventerventions to preventers.	or time of administration was her or the line from the dent. 2 on October 8, 2012, at 4:35 nursing station, revealed the solution began on October n., and confirmed the facility the time and date of in the label. ACCIDENT ISION/DEVICES The that the resident hazards as free of accident hazards as free of accident hazards and assistance devices to is not met as evidenced cord review, observation, igation, and interview, the proper use of safety its (#8, #13), falled to fety of one resident (#8) Hoyer lift, falled to implementation of new to transfer one resident to transfer one resident.	F 323	participants signature on the in" sheet. Responsible Person: Direct Nurses Compliance rate will be detent by the # of Residents entera containers that are labeled a	ermined I feeding Ind dated I feeding Ind dated I feeding Ind dated I feeding I feedin	
['''	e minniña Weladea:	,	Į		1	}
CMR-25A7/A	2-89) Previous Version Chara	i			<u> </u>	

page 6 2012-10-22 13:50 Dept of Health-HUF **80000740107 >>** r 0/14 UEPAKI MENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/OUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 445071 10/10/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CLAIBORNE COUNTY NURSING HOME 1850 OLD KNOXVILLE ROAD TAZEWELL, TN 37879 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (KS) GOMPLETION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY F 323 i Continued From page 4 F 323 Resident #8 was admitted to the facility on May F323 11, 2011, and readmitted to the facility on May Employee that was involved in 29, 2012, with diagnoses including Gestroslomy, 11/16/12 Failure to Thrive, Congestive Heart Failure, the deficient practice involving Hypoxemia, Rheumatoid Arthritis, Vascular Resident # 8 on 04/08/2012 was Dementia, and Psychosis, counseled about the importance of making sure alarms are Review of the Quarterly Minimum Data Set (MDS) dated September 12, 2012, revealed the applied and operating properly. resident had severely impaired cognition and No further occurrences involved required extensive assistance with activities of this employee. dally living (ADLs). Responsible Person: Director of Observation of the resident's room on October 8, Nurses 2012, at 2:15 p.m., revealed alarms and motion sensors to each side of the resident's bed and fall mats to both sides of the resident's bed. Employee that was involved in Observation of the resident on October 8, 2012, the deficient practice involving at 2:30 p.m., outside the second floor nurse's Resident # 8 on 07/29/2012 was station, revealed the resident sitting in a rocking counseled about the importance wheelchair with sensor alarms to each side of the of making sure alarms are wheelchair and a wanderguard bracelet attached applied and working properly. to the resident's right ankie. No further occurrences involved Review of facility investigations dated October 1, this employee. 2011, October 29, 2011, Novmber 2, 2011, November 14, 2011, December 29, 2011, and Responsible Person: Director of Nurses

March 3, 2011, revealed the resident had falls without injury. Continued review revealed interventions of "...continue low bed, alarm...respond to alarms quickly...Make sure bed alarm pad laying horizontal...continue low bed and alarms...continue low bed with fall mate bilaterally...continue to keep fall mats at bedside and respond to alarms, continue low bed.."

Review of a facility investigation dated April 5.

Employee that was involved in the deficient practice involving Resident # 8 on 09/19/2012 was counseled about the importance of following the Resident's plan

of care for the safety of the

2012-10-22 13:50. Dept of Health-HCF

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P 7/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <u>OMB NO.0938-039</u>. 000 MULTIPLE CONSTRUCTION (XS) DAYE SURVEY COMPLETED A BUILDING B. WING 445071 NAME OF PROVIDER OR SUPPLIER 10/10/2012 STREET ADDRESS, CITY, STATE, ZIP CODE CLAIBORNE COUNTY NURSING HOME 1850 OLD KNOXVILLE ROAD TAZEWELL, TN 37879 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION) (X4) ID i PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG PREFIX COMPLETION TAG DATE **DEFICIENCY**) F 323 Continued From page 5 F 323 Resident and employees. No 2012, revealed the resident while seated in a wheelchair in front of the second floor nurse's further occurrences involved this station, flipped the wheelchair over without injury. employee. Continued review of the facility investigation Responsible Person: Director of revealed alarm on wheelchair "...was not turned Nurses ٥n...۲ Review of facility investigations dated June 2, 2012, June 12, 2012, June 15, 2012, July 4, 2012, Employee that was involved in July 18, 2012, and July 20, 2012, revealed the the deficient practice involving resident had falls without injury. Review of the facility investigations revealed interventions of Resident # 13 on 04/17/2012 was ...alerm on resident at all times, instructed counseled about the importance daughter...Place bolsters on sides of of making sure the Resident bed...monitor frequently, maintain alarms, PT alarm is applied and operating (physical therapy) screen...continue use of low beds and alarms...monitor resident frequently properly. No further occurrences when restless behavior...continue low bed and involved this employee. respond to alarms as quick as possible... Responsible Person: Director of Continued review revealed no new interventions Nurses implemented to prevent further falls on on July 4, 2012, or July 20, 2012. Review of a facility invastigation dated July 29, Employee that was involved in 2012, revealed the resident had a fall on in the the deficient practice with resident's room resulting in no injury to the resident. Continued raview of the facility Resident # 12 on 06/11/2012 was investigation revealed safety alarms were not counseled about the importance sounding, mobile alarms did not detach from the of following the Residents care resident, end "...motion sensor turned off...AC plan for the safety of Resident adaptor not plugged into alarm,..." and employee. No further Review of facility investigations dated August 14, occurrences involved this 2012 and August 31, 2012, revealed the resident employee. had falls without injury. Continued review Responsible Person: Director of revealed no new interventions were implemented to prevent further falls after the August 14, 2012, Nurses

fati. Continued review revealed interventions of

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CENT	ERS FOR MEDICARE & MEDICAID SERVICES	•	•	FORM	APPROVE
ISTATEME	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	O(2) MU	ILTIPLE CONSTRUCTION DING	OMB NO.	0938-039 URVEY
		e. wind)	
NAME OF	PROVIDER OR SUPPLIER			10/1	0/2012
CLAIBC	RNE COUNTY NURSING HOME	}	FTREET ADDRESS, CITY, STATE, ZIP CODE 1850 OLD KNOXVILLE ROAD TAZEWELL, TN 97879		
(X1) ID PREFIX TAG	SUMMARY STATEMENT OF DESIGNACIES (EACH DEFICIENDY MUST BE PRECEDED BY FULL REGULATORY OR LOCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT	ULD BE i	COMPLETION DATE
THOUSE FINNE	Continued From page 6 "monitor frequently when up in w/c (wheelchair) and reposition resident back in w/c when needed, OT (occupational therapy) to screen" Review of a facility investigation dated September 19, 2012, revealed the resident was dropped without injury during a transfer to bed by one staff person using a Hoyer lift (device used to transfer residents who cannot safely transfer themselves). Further review of the facility investigation revealed, "should have x2 (times two) staff with transfers with lift" Medical record review of the Care Plan updated on September 20, 2012, revealed, "Only 1 CNA (Certified Nurse Assistant) was present at time of fall. 2 CNA (s) are supposed to be present during TF (transfer) with lift" Interview on October 9, 2012, at 2:46 p.m., with the Director of Nursing (DON), in the DON's office, confirmed the safety devices in place at the time of the resident's falls on April 5, 2012, and July 29, 2012, were not functioning properly. Continued interview with the DON confirmed two test members were required to be present while ansferring the resident with a Hoyer lift and the esident's care plan was not followed resulting in fall on September 19, 2012. The property of the confirmed no new terventions were implemented after falls on ovember 14, 2011, December, 29, 2011, and arch 31, 2012. Total under the property of the present confirmed interview confirmed "were not aware other interventions to be attempted" on		removed Resident #8 bilate length bed rails, as a new intervention to help decreat number of repeated "roll or low beds. All other furnitude been moved from area of "outs" to prevent injury. Responsible Person: Direct Nurses 100% of the Nursing Home direct patient care staff will educated on the importance compliance with facility pot and procedures and individe Resident's care plan, for the safety of the Resident and the staff. Emphasis to be made correct application of safety monitors and validation of the functionality. Emphasis with the made on the necessity and importance of compliance windividual Resident's care pattendance of education sessions will be verified by participation signature on the "sign-in"	se the uts" of re has roll- stor of licies ual e he on of their ll also ad with plans. ssion ants heet.	
101	other interventions to be attempted" on iditional falls which occurred on July 4, 2012,		Nurses	OI OI	

2012-10-22 13:51 Dept of Health-HCF DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTEDO COD.

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P 9/14

FORM APPROVED <u>OMB NO, 0938-0381</u>

ETATOLENS FOR MEDICARI	<u>E & MEDICAID SERV</u>
STATEMENT OF DEFICIENCIES	
AND PLAN OF COORECTION	(XI) PROVIDER/SUPPLIER

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

PCS MULTIPLE CONSTRUCTION

(XX) DATE SURVEY COMPLETED

445071

A. BUILDING 8. WING

10/10/2012

(XS) GOMPLETION

NAME OF PROVIDER OR SUPPLIER

(X4) ID PREFIX

TAG

CLAIBORNE COUNTY NURSING HOME

Street Adoress, City, State, ZIP code 1860 OLD KNOXVILLE ROAD TAZEWELL, TN 37879

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE

Cross-referenced to the appropriate DEFICIENCY

F 323 Continued From page 7 July 20, 2012, and August 14, 2012.

> Resident #13 was admitted to the facility on September 11, 2010, with diagnoses including Cerebrovascular Accident, Altered Mental Status, Old Myocardial Infarction and Parkinson's Disease.

SUMMARY STATEMENT OF DEFICIENCIES

(BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

Observation of the resident in the resident's room, on October 10, 2012, at 9:45 a.m., revealed the resident lying in bed with a full padded side rall up on the right side of the bed. Continued observation revealed an alarm hanging from the side rall of the bed.

Review of a facility investigation dated April 17, 2012, revealed "...found R (resident) on BR (bedroom) SOB (side of bed)...alarm attached to R and bed still..." Further review revealed. "...make sure mobile alarm is attached to bedrell where will not slide with resident...

Interview on October 10, 2012, at 10:20 a.m., with the DON, in the DON's office, confirmed the facility had falled to ensure the safety alarms were applied correctly to elert staff of unassisted transfers.

Resident #12 was admitted to the facility on January 12, 2012, with diagnoses of Renal Dialysis, Chronic Kidney Disease, Malaise and Fatigue, and Diabetes Mellitus Type II.

Medical record review of the Care Plan revealed the resident fell on May 2, 2012, with no injury, and the Care Plan had been updated to include interventions to prevent falls including "... assist of two for transfers..."

F 323

PRĚFIX

TAG

Compliance rate will be determined by monitoring the # of Residents that have alarms that are attached and operating properly / total # of Residents with alarms in use = rate of compliance. Expected compliance is expected to be 100%. Daily walk through rounds by licensed staff will be used to gather compliance data in conjunction with daily monitoring of each event report. The licensed staff will provide the data to the Director of Nurses. The Director of Nurses will aggregate the data and report the compliance rate to the Administrator and Medical Director on a monthly basis. Monitoring will continue until compliance rate of 100% is obtained and maintained for at least 3 consecutive months. Responsible Person: Director of Nurses

FORM CMS-2567(02-99) Provious Versions Chisolote

Event ID: 614411

Facility ID: TN1301

if continuation sheet Page 8 of 12

7.20

2012-10-22 13:51 Dept of Health-HCF

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DEPARTMENT OF HEALTH AND HUMAN SERVICES P 10/14 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IX23 MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING 445071 B. WING NAME OF PROVIDER OR SUPPLIER 10/10/2012 STREET ADDRESS, GITY, STATE, ZIP CODE CLAIBORNE COUNTY NURSING HOME 1850 OLD KNOXVILLE ROAD TAZEWELL, TN 37879 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIK PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE in PREFIX REGULATORY OR LEC IDENTIFYING INFORMATION) TAG COMPLETION TAG DEFICIENCY F \$23 | Continued From page 8 F 323 Bullet # 2 of POC For F323 Continued medical record review of the Care Plan revealed the resident fell again on June 11, 2012, 100% of residents with alarm and was updated to include "...Resident was lowered to floor during transfer with assist x1. devices and side rails were Resident needs assist x2 for safe transfers..." checked by Charge nurses for functioning alarms and proper Review of a facility investigation dated June 11, placement 10/11/2012, 100% of 2012, revealed "...transfer with assist of one with devices checked were found to be fall...care plan called for assist of two...educate properly attached and with CNA (Certified Nursing Assistant) on following functioning alarm. Only the one care plan for assist of two on transfers...PT bedrail of Resident #8 required (Physical Therapy) to evaluate..." intervention. Daily assessments Interview with the Assistant Director of Nursing made by licensed personnel. (ADON), in the DON's office, on October 10, Responsible Person: Director of 2012, at 10:20 a.m., confirmed the resident's fall Nurses on June 11, 2012, was the result of the CNA not following the care plan. F 441 , 483.65 INFECTION CONTROL, PREVENT F 441 SS=D: SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, senitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -(1) investigates, controls, and prevents infections in the facility: (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective

actions related to infections.

ZUIZ-10-ZZ 13:31 Dept of Health-HCF 8000740/3Y >> P 10/14 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB_NO. 0938-0391 STATEMENT OF DEFICIENCIES IXXI MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED . A. BUILDING B. WING 445071 10/10/2012 NAME OF PROMOER OR SUPPLIER STREET ADDRESS, CITY, STAYE, ZIP CODE 1850 OLD KNOXVILLE ROAD CLAIBORNE COUNTY NURSING HOME TAZEWELL, TN 37879 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSO IDENTIFYING INFORMATION) (X4) ID COPPLETION DATE DC2) Ю PREFIX PREFIX TAG TAG DEFICIENCY F 323 Continued From page 8 F 323 Continued medical record review of the Care Plan revealed the resident fell again on June 11, 2012. and was updated to include "...Resident was lowered to floor during transfer with assist x1. Resident needs assist x2 for safe transfers..." Review of a facility investigation dated June 11, 2012, revealed "...transfer with assist of one with fall...care plan called for assist of two...educate CNA (Certified Nursing Assistant) on following care plan for assist of two on transfers...PT (Physical Therapy) to evaluate..." Interview with the Assistant Director of Nursing (ADON), in the DON's office, on October 10. 2012, at 10:20 a.m., confirmed the resident's fall on June 11, 2012, was the result of the CNA not following the care plan. F 441 483.65 INFECTION CONTROL, PREVENT F441 F 441 SS=D: SPREAD, LINENS Immediately after the nurse The facility must establish and maintain an became aware of the identified 11/16/12 Infection Control Program designed to provide a deficient practice involving

safe, senitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -

(1) Investigates, controls, and prevents infections in the facility:

(2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.

Resident #3, the undated nebulizer mask was removed and replaced with a new mask with date placed on the mask. 100% of Residents with orders for nebulizer masks/treatments were checked to make sure masks were clean and dated. Responsible Person: Director of Nurses

FORM CMS-2587(02-09) Previous Versiona Obsolete

Event ID: 616411

Facility ID: TN 1301

If continuation sheet Page 9 of 12

DEPAR	TMENT OF HEALTH	PL OF RESERVICES AND HUMAN SERVICES & MEDICAID SERVICES	~ `		OMB NO	APPROVE 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER:	(X2) MULT A BUILOD	IPLE CONSTRUCTION VG	(X3) DATE S COMPL	
İ		445071	a. WING_		10/	10/2012
	PROVIDER OR SUPPLIER RNE COUNTY NURSI	NG HOME	1	REET ADDRESS, CITY, STATE, ZIP GO 1850 OLD KNOXVILLE ROAD [AZEWELL, TN 37879	DE	
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1.0	determines that a re- prevent the spread isolate the resident. (2) The facility must communicable dise from direct contact will the (3) The facility must hands after each dir hand washing is ind professional practice (c) Linens Personnel must hand	ad of infection ion Control Program askient needs isolation to of infection, the facility must prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. require staff to wash their ect resident contact for which icated by accepted	F 441	100% of the licensed nestaff will be educated of importance of compliations and professing on scheduled and dating nebulizer meekly and PRN basis. Attendance of education will be verified by participations on the "sign-Responsible Person: In Nurses	on the nce with ocedures, changing asks on a on session ticipant in" sheet. Director of	
	by: Based on observation of the reservation of the feature. In the feature of the feature of the findings included the findings incl	nitted to the facility on July pages of Gastrostomy Status, Agitans, Hernatemesis, stroduodenal Disease, and		Compliance rate will be determined by the # of Resident's that have not masks that are dated as Total # of Residents we for nebulizer masks or = rate of compliance. compliance is to be 10 walk through rounds be charge nurses will be ugather compliance date charge nurses will provide to the Director of who will aggregate and The Director of Nurses report the compliance Administrator and Medical Administrator and Medical Resident Police of Nurses report the compliance Administrator and Medical Resident Police of Nurses report the compliance Administrator and Medical Resident Police of Nurses Resident Police of	ebulizer and clean / with orders treatments Expected 0%. Daily y the used to a. The vide the Nurses d trend it. s will then data to the	

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2012-10-22 13:51 Dept of Health-HCF DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

P 12/14 FORM APPROVED

	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) age 10 or face mask in a clear plastic without the resident's name, of a yellow substance inside	A. BUIL B. WIN	STREET ADDRESS, CITY, STATE, ZIP CODE 1860 OLD KNOXVILLE ROAD TAZEWELL, TN 37879 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY) F 441 Cont.	OULD BE GOMPLETION DATE
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	or face mask in a clear plastic without the resident's name, of a yellow substance inside	F 44	Director monthly for at le	ast
and had a buildup of the mask. Review of facility por October 2008, revenue had a buildup of the mask. Review of facility por October 2008, revenue had a buildup of the residents' room in the residents' room in the residents' room in the residents' room in the residents' room in the residents' room in the residents' room in the residents' room interview confirmed in the room interview confirmed in the room in the room in the room in accordance standards and practice accurately documented systematically organizes the clinical record multinformation to identify resident's assessment services provided: the	ntain clinical records on each e with accepted professional es that are complete: d; readily accessible; and ed, st contain sufficient the resident; a record of the	F 514	compliance is achieved for consecutive months. The Director of Nurses will repeth this data to the Quality management Committee bimonthly at scheduled mediately after staff becaware of the deficient practice.	ained or three port port port port port port port port
This REQUIREMENT	is not met as evidenced		Completion Date: 10/12/20	012

2012-10-22 13:51 Dept of Health-HCF DEPARTMENT OF HEALTH AND HUMAN SERVICES

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P 13/14

CENTI	ERS FOR MEDICARE	& MEDICAID SERVICES				M APPROV <u>D. 093</u> 8-03
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILC	LTIPLE CONSTRUCTION DING	00) DATE SURVEY COMPLETED	
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	the facility falled to it accessible clinical relegation residents in eighteen residents in The findings included Resident #13 was ad September 11, 2010. Cerebrovascular Accord Myocardial Infarcold Myocardial Infarcold Myocardial Infarcolds revealed the Forders were last signification on July 27, and for more than 60 medical record review hysician Recapitulation of the Second after July 27, 20 interview on October 1 the Director of Nursing filice, confirmed Physician, accord after July 27, 20 interview on October 1 the Director of Nursing filice, confirmed Physician, according the Director of Nursing filice, confirmed Physician, according to the Director of Nursing Filice, confirmed Physician Recapitulation, according to the Director of Nursing Filice, confirmed Physician Recapitulation, according to the Director of Nursing Filice, confirmed Physician Recapitulation, according to the Director of Nursing Filice, confirmed Physician Recapitulation, according to the Director of Nursing Filice, confirmed Physician Recapitulation, according to the Director of Nursing Filice, confirmed Physician Recapitulation, according to the Director of Nursing Filice, confirmed Physician Recapitulation, according to the Director of Nursing Filice, confirmed Physician Recapitulation, according to the Director of Nursing Filice, according to the Physician Recapitulation according to the Physician Recapitulation according to the Physician Recapitulation according to the Physician Recapitulation according to the Physician Recapitulation according to the Physician Recapitulation according to the Physician Recapitulation according to the Physician Recapitulation according to the Physician Recapitulation according to the Physician Recapitulation according to the Physician Recapitulation according to the Physician Recapitulation according to the Physician Recapitulation according to the Physician Recapitulation according to the Physician Recapitulation according to the Physician Recapitulation according to the Physician Recapitulation ac	ecord review and interview, naintain a current and readily cord for one resident (#13) of aviewed. I: imitted to the facility on with diagnoses including ident, Altered Mental Status, ident, Altered Mental Status, ident, Altered Mental Status, ident, Altered Mental Status, ident, Altered Mental Status, ident, Altered Mental Status, ident, Altered Mental Status, ident, Altered Mental Status, ident, Altered Mental Status, ident, Altered Mental Status, ident, Altered Mental Status, ident, Altered Mental Status, ident, Altered Mental Status, identification and dated by the 2012, and "No order may 0 days" Continued revealed no additional on orders in the medical 012.	F 514	100% of physician recapitate orders will now be complete every 30 days, with Reside charts divided relative to room/floor assignment. The division will promote continuant eliminate the possibility oversight. 100% of licensed nursing so will be educated on this reversight. 100% of licensed nursing so will be educated on this rotating schedule. Attendance of the education session will be validated by employee sign on the "sign-in" sheet. Responsible Person: Direct Nurses 100% chart review will be conducted by Director of Nurses 100% chart review will be conducted by Director of Nurses 100% chart review will be conducted on each floor. # charts with completed recapitulation is scheduled recapitulation / Total # of Resident charts due recapitulation = % compliant Expected compliance rate is 100%. The Director of Nurwill aggregate this data and	ted ent is inuity y of taff vised e of urses date to be of	

page 14 8655945.739 >> 2012-10-22 13:51 Dept of Health-HCF DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA AZI MULTIPLE CONSTRUCTION くまいがしき ゴデムび (たく) IDENTIFICATION NUMBER: COMPLETED A. GUILDING B. WING 445071 10/10/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, SYATE, ZIP CODE 1850 OLD KNOXVILLE ROAD CLAIBORNE COUNTY NURSING HOME TAZEWELL, TN 37879 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE O(4) 10 JD PREFIX (XS) COMPLETION DATE TAG TAG DEFICIENCY) F 514 | Continued From page 11 F 514 F514 Continued Based on medical record review and interview, report compliance rate monthly the facility failed to meintain a current and readily to the Administrator and accessible clinical record for one resident (#13) of eighteen residents reviewed. bimonthly at scheduled Quality Management Committee The findings included: meetings. This will be done for at least 3 months or longer until Resident #13 was admitted to the facility on September 11, 2010, with diagnoses including sustained acceptable compliance Cerebrovascular Accident, Altered Mentel Status, is achieved and maintained. Old Myocardial Infarction and Parkinson's Olsease. Medical record review of Physician Receptialistion Orders revealed the Physician Recapitulation Orders were last signed and dated by the Physician on July 27, 2012, and "...No order may stand for more than 60 days..." Continued medical record review revealed no additional Physician Recapitulation orders in the medical record after July 27, 2012. interview on October 10, 2012, at 9:10 a.m., with the Director of Nursing (DON) in the DON's office, confirmed Physician Recapitulation Orders were not current and not in the resident's chart,

FORM CMS-2567(02-09) Provious Versions Objecto

Event t0:814411

Facility ID: TN1301

If continuation sheet Page 12 of 12